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Abstract

The UK construction industry employs over 2.9 million workers and issues of mental health has become top priority across the industry and beyond. It is estimated that 44% of employers are experiencing increase in reported cases of mental ill health. This is estimated to cost the UK economy around £26 billion a year and as much as 400,000 workdays lost annually. The construction industry recognizes the significance of occupational health and safety in protecting the physical health of workers. However, mental illness which is unseen and affects significant numbers of workers is rarely discussed within the industry. Around 89% of the construction workforce is male and national statistics show that approximately 75% of suicides are men under the age of 45. These include low-skilled workers like labourers; skilled trades like plasterers, painters and decorators and construction managers. Women however, who suffer from mental ill health are twice as likely to seek help. This study adopts an ethnographic approach by evaluating construction workers that have attended the 7-day Instructor training. This training include a 2-days Mental Health First Aid training and 5-days of instructor training to appraise the suitability of MHFA training for the construction industry; and if the training improves the physical, mental and social health of workers. All of these were weighed against the deliverables that MHFA England set out to achieve with the use of their training. Within the industry, workers that are physically and mentally able are more willing to contribute to their workplace and most likely to be meaningfully engaged. It is therefore imperative to create a supportive environment that manages the risks to worker's mental health by raising awareness, reducing stigma and discrimination and upskilling workers at all levels towards understanding mental ill health and how to recognize and manage such issues.

Keywords: mental health first aid, construction work, mental health

1. Introduction

Mental health issues within the workplace have serious consequences not only for the individual involved, but also for the workplace as a whole and the economy in the grand scale. It is suggested that workers with a better mental health are more productive, less prone to absenteeism or presenteeism, decreased motivation and extended sickness leave. In the construction industry, poor mental health could also result in accidents and injuries for both the individual and their colleagues. The overall economic cost of poor mental health for the UK is around £70 to £80 billion annually (OECD, 2018) with more than 15.8 million working days lost per year (Office for National Statistics, 2017). It is estimated that the UK construction industry has around 400,000 workdays lost every year due to depression (Burki, 2018). However, the biggest loss is the lives of the workers due to poor mental health, and the industry has by far, the highest rates of suicide out of all professions (Meltzer et al., 2008; Roberts et al., 2013). Over the period of 2011 to 2015, low-skilled workers were three to seven times more likely to take their own lives compared to the national average (Burki, 2018).

Mental ill health in construction are largely connected to demographics. Around 89% of the construction industry workforce is male. Men are more likely to die from suicide due to gender-based factors, such as lack of help-seeking behaviours, social stigma attached to mental health and self-medicating through substance and drug misuse (Martin et al., 2016; Turner et al., 2017; Burki, 2018). Also, older construction workers (over the age of 50) were found to be more prone to alcohol abuse as a coping mechanism when dealing with stress (Lim et al., 2017), and are less likely to seek help for mental health issues or substance abuse.

The construction industry is considered to operate within strict rules and deadlines. The work of Karasek Jr. (1979) which addresses the risk factors of working in the lower tier within the construction industry developed the job-demand-control theory. Mental strain results from the interaction of job-demands and job-decision latitude while psychological strain in the work environment has multifaceted origins. This could be the joint effect of freedom to make own decisions within the workplace and existing demands at work. Construction workers face lots of pressure from work, and frontline workers are on the lowest tier in terms of decision-making (Lawani et al., 2017). They are exposed both to physical and mental demands, with little to no protective or mitigating factors, and are at a high risk for occupational stress (Abbe et al., 2011).

1.1 Mental Demands and Mental Ill Health by Occupation in the Construction Sector

Construction workers generally face long working hours; long commute to project sites; high pressure ´hire and fire´ culture; job transient nature; taking responsibility for own safety and that of others´ at work; and the overall dangerous nature of the work they are required to carry out (Beswick et al., 2007). Each tier of worker faces challenges specific to their job role, work environment, targets and demands e.g. bricklayers have been found to experience significantly worse job control and opportunities to upskill, while construction supervisors have significantly higher psychological demands and longer need for recovery during after-work hours (Boschman et al., 2013).

Boschman et al. (2013) assessed two professions within the construction industry in the Netherlands – bricklayers and construction supervisors in terms of self-reported mental ill health. The result indicates that there were higher levels of depression for supervisors (20%) than for bricklayers (18%), and higher levels of distress (5% as opposed to 7%). Bricklayers had a higher prevalence for post-traumatic stress disorder (PTSD) (11%) than supervisors (7%). For both professions, the incidence of depression was higher when compared to the general Dutch population. In the UK, depression is one of the most common diagnoses for construction workers (Brenner & Ahern 2000) and the prevalence of PTSD among construction workers is disproportionally high as well (Stocks et al., 2010).

Lim et al. (2017) extensively studied various conditions that provoke stress in construction workers. The origins of stress within construction workers were highly customized, depending on the length of their work experience, their work conditions, their employment status, and their demographic information. Married workers were more likely to experience stress from job insecurity; younger workers were found to deal more poorly with stress due to lower level of experience in handling job demands and structuring tasks, while workers over the age of 50 had higher levels of chronic stress due to insufficient job control and poor coping habits leading to increased alcohol abuse.

1.2 Ongoing approaches to tacking Mental Health

The psychological needs within the construction industry are diverse and a one-size-fits-all model for mitigating mental health issues and stress within the industry would only be superficially effective. There are attempts to raise awareness about mental health within the industry to mitigate mental ill health amongst construction workers. A mental health charity Mates in Mind was launched with the aim to inform and improve the understanding of mental health issues in the construction industry. Mates in Mind use available organizations such as Mental Health First Aid England, Samaritans and Mind and public resources to support workers and employers in the construction sector by offering a two-day mental health first aid courses through MHFA England, exclusive to Mates in Mind Supporters, after which the participants become certified Mental Health First Aiders.

Similarly, the construction company Willmott Dixon launched an All Safe Minds campaign to tackle mental health issues in the workplace (Willmott Dixon, 2018). However, there were differences between All Safe Minds and Mates in Mind, e.g. the former putting more emphasis on supporting young men across the construction sector, as they are one of the most vulnerable demographic (Lim et al., 2017; Pidd et al., 2017). The two programs remain largely similar because they have chosen the same organization – Mental Health First Aid England – to train those in the construction sector to be MHFAiders. MHFA was initially designed as a nine-hour course, based on the design used for physical first aid training. The purpose of MHFA is to equip members of the general public in recognizing mental ill health in others, providing support and information to those in crisis, and signposting them to professional help. It does not however, provide participants of this training with qualifications in therapy, counselling, or psychological expertise, the same way that physical first aid training does not provide in-depth medical knowledge.

1.3 The effectiveness of MHFA in the workplace

The effectiveness of the MHFA training has since been evaluated on multiple levels regarding its effectiveness for the general public in raising awareness of mental health issues and increasing supportive behaviours and minimizing negative attitudes towards mental ill health (Kitchener and Jorm 2002). As a result of this, MHFA has become the focus of government funding with Public Health England allocating 15 million pounds to train up to 1 million people in mental health first aid, through MHFA England. The trend continues in the educational sector, as 5 million pounds was also invested in training teachers to recognise and respond to mental ill health of primary school children (GOV.UK, 2017).

The literature on the impact of MHFA within a workplace setting is predominantly limited to white-collar, office professions. A recent study commissioned by the Institution of Occupational Safety and Health (IOSH) and University of Nottingham looked at the implementation, use and utility of a Mental Health First Aid course in the workplace (Narayanasamy *et al.*, 2018). Participants reported increased understanding of mental health issues, increased confidence surrounding MH issues, increased conversations about MH, improved signposting techniques, as is within the scope of deliverables that MHFA England outlined (MHFA England, 2018a). Additionally, mini case studies were conducted,

dividing the sample of participants according to the type of organisation they work. One interviewee from this group (construction and rail work) identified that a greater spread of professions and a balance of gender and job types would have been beneficial during the training, as most participants were 'office based' (Narayanasamy *et al.*, 2018). In addition, because construction industry is male-dominated, the interviewees did not feel that MHFA was tailored to focus a bit more on the industry specific challenges and men's mental health (Narayanasamy *et al.*, 2018). The study identified some challenges in measuring the impact and success of MHFA in the workplace, and the need to establish boundaries around the MHFA trained person, giving them adequate support when dealing with the mental health problems of others. The study highlighted that whilst there are reports of success of using MHFA in the workplace, the ways the success or effectiveness is measured is anecdotal and based on individual cases.

The study concluded that some of the expectations of MHFA training have been met for those who completed it, but majority of the participants could not confidently attribute any positive changes in the workplace to the training. One of the limitations of MHFA that was addressed within the study was that MHFA in itself, does not give tools to tackle any underlying issues within a workplace, such as workplace stigma, job design, workplace-induced stress, and it is not workplace specific.

The HSE published a review of all current evidence of the effectiveness of MHFA in the workplace between 2000 and 2017 (Bell *et al.*, 2018), based on 22 studies. Only three of these studies met the highest quality score criteria; i.e. two single studies and one single study protocol all based on self-reporting. The three key research areas captured in the review include: if there has been an increase in awareness of mental health amongst employees receiving MHFA training (including improved attitude towards mental health as a reduction of stigma, recognising when someone is in crisis, knowing how to provide help and support); evidence of improved management of MH in the workplace as a consequence of the introduction of the training; and evidence that the content of the MHFA training has been considered for workplace settings (the sector, size of the organisation, the needs and culture). The study found that there is consistent evidence that MHFA training raises employees' awareness of mental ill health and mental health problems, conditions and symptoms. Those who have attended the training have a better understanding of where to find relevant information, where to access support and are more confident in helping other individuals going through a crisis or experiencing mental health issues.

However, there is a lack of published evidence from occupationally-based studies that justifies that the content delivered by MHFA is tailored towards specific workplace settings. Furthermore**,** there is no evidence that introducing MHFA training in workplaces has resulted in sustained actions in those who were trained, or that it has improved the wider management of ill-health, although studies by Kitchener and Jorm (2006); Hadlaczky *et al.*, (2014); and Booth *et al.*, (2017) reported positive improvements amongst public sector workers immediately following the training and up to 6 months after. The HSE study concludes that there was only anecdotal evidence that MHFA training improved organisational outcomes resulting in fewer employee claims for stress related illness (Bell *et al.*, 2018).

2. Research methods and discussion of the structure of the MHFA training

The evidence supporting the impact of MHFA within the workplace is limited and there are no extensive reviews or studies regarding the impact of MHFA training specific to the construction industry. Narayanasamy et al. (2018) recognized that the biggest challenge lies in measuring the impact of MHFA training within the workplace and identifying the key factors from MHFA that promote good mental health. This paper is based on completing the MHFA 7-day instructor training, which consists of the 2-day adult MHFA course and the 5-day instructor training. It covers the lived experience of participants from the construction industry attending the MHFA 7-day training through evaluating the effectiveness of the training as perceived by the participants. The two-day MHFA training is the primary focus of the 7-day course, as it is meant to provide the greatest benefit not only to the participants of the MHFA course, but also to the potential participants they would go on to interact with and give support to after

completing the training.

Twelve participants attended the 7-day MHFA instructor training over the course of one month. The training began with the 2-day Adult Mental Health First Aid course while the third day was dedicated to guest speakers, with some of the speakers having previously attended a MHFA course themselves, or have personally experienced mental health issues. Day 1 began with introductions and a talk from a guest speaker from the construction industry regarding the high suicide rates in the sector; the importance of promoting mental health in the workplace; and how having mental health first aiders on a construction site could mitigate the rise of mental health issues. By the afternoon, the MHFA training had begun and was completed at the end of day 2.

Before the end of day 3, each participant was assigned a topic on mental health and required to give a 25-minute presentation, including a choice of group facilitation task related to the topic for either days 4 or 5. Each participant received feedback from the group at the end of their sessions, as well as individual feedback from their mentor (the MHFA England instructor). Days 4 and 5 marked the start of the instructor training. At the end of day 5, the participants were given a final task for either days 6 or 7 – to deliver part of the MHFA two-day adult course and the participants received both group and individual feedback. A closing message was delivered by the instructors on day 7 and participants were encouraged to give both verbal and written feedback on the whole 7 days training including any further questions. The instructors debriefed the participants on the final step towards becoming certified MHFA instructors and this include two co-deliveries that must be completed by each participant in order to be signed off as approved MHFA Two-day Adult course trainers. The two co-deliveries must be completed within one year of attending this training by the participants, and subsequent mental health events and refresher courses must be attended by the participants.

The 12 participants on the course exclusively work in the construction sector. Through their own stories, experiences and discussions, it was clear that they were familiar with the rising mental health issues in their workplaces, and the impact that these issues have on the construction industry as a whole. The primary objective for the 12 participants was to act as mental health ambassadors within their workplaces; gain knowledge and understanding on mental health issues; and be a point of help for those who need it. Secondary to that, the participants expressed their desire to train others to be MHFAiders, so that more help would be available to those who need it. They admitted that their knowledge of mental health issues has changed with some participants having first-hand experiences personally or having family members, friends or colleagues struggling with mental ill health. Based on the guest speaker on day 1, the participants acknowledged that the message was close to home for them, and they all wanted to contribute to reducing mental health issues in their workplace.

After day 1 of the training, the participants shared their thoughts with other members of the group and some of their unanswered questions echoed those voiced by the participants in the IOSH study (Narayanasamy *et al.*, 2018). What is the MHFAiders' level of responsibility within the workplace; what boundaries are set to protect them and those that they help; how would they adapt MHFA practices to suit the construction industry? Some of the participants questioned if the training could focus more on industry specific issues (e.g. substance misuse, depression, suicide), so as to maximise its applicability within the construction sector. However, the instructors are not allowed to customise the training or deviate too much from the MHFA England approved script. The same message was passed to the participants after completing the 7-day instructor training – the core training material of the Two-Day Adult MHFA course cannot be altered, and any examples created (such as educational case studies about construction workers) and wish to present to their own training participants must first be approved by MHFA England. Other questions included how the participants should implement MHFA training alongside existing health and safety policies on construction sites.

The participants commented that the knowledge they gained during the MHFA training has equipped them to have difficult conversations with those who experience mental health issues and effectively signpost them to relevant services or other professional help. However, there were some issues regarding confidentiality, and akin to the IOSH report, (Narayanasamy *et al.*, 2018), there were issues

with logging such incidents or following up the person who has received help. The participants admitted that the group activities equipped them best for real life situations, but they had reservations regarding the relevance of some of the case studies as they were not industry specific. The fact that the participants cannot include their own case studies to make the training material more relevant for their audience due to the strict standards of MHFA England made them question the adaptability of the training.

3. Findings & Discussion

Discussions with participants regarding the future of MHFA in the construction industry centered on management issues; legislation that makes it mandatory for companies and employers to address mental ill health; stigma and culture within the construction industry; tailoring MHFA to reflect the needs of the construction industry; and finding ways to measure the impact of MHFA within the industry.

The discussions around management issues referenced the need for CEO's and employers within the construction industry to be trained as MHFAiders:

"Train all CEO's as Mental Health First Aiders to increase their awareness of mental health issues."

This will encourage buy-in from senior management and other top management to undergo the MHFA training scheme. This heavily reflects the prospective cultural change from top-to-bottom within the industry. This could potentially bring about a cohesive and united 'support from all hierarchy' in tackling the 'toxic culture' within the construction industry. Poor mental health is a core issue within the industry and involving external organizations for support to successfully implement MHFA within the workplace and to set guidelines and guidance similar to physical first aid training would be beneficial to the industry.

MHFA England was created to address general mental ill health issues of the population. The participants suggested that aspects of the training should be more construction industry focused, and employ more specific training geared towards the construction industry. Due to the complexity of the industry and existing health and safety procedures, the participants suggested that MHFA should be incorporated into legislations relevant to workplace health and safety, mandatory for all notifiable projects and companies with 10 or more employees, and covered in site inductions. The participants suggested that in future projects, mental health should be considered in risk assessments in a similar way as occupational health, but this would require further education of trainees formally part of [MHFA] training program.

Stigma associated with mental ill health still remains the number one challenge in the construction industry. Stigma is known to promote the toxic culture and hinders positive change in tackling mental ill health, see Figure 1. Stigma plays a major part in how MHFA and mental health in general is perceived within the industry based on the responses from participants regarding the number one issue within the construction industry. Amongst the participants, there was unanimous agreement that stigma must be removed so that people are comfortable discussing issues related to Mental Health. Also, a shift in the mindset around mental health being 'a normal discussion' rather than a taboo subject needs to be encouraged. The removal of stigma could begin with promoting the increasing successful stories of mental health interventions as a result of mental health first aid to reinforce positive change. Also, detailing anonymous successful cases where MHFA has helped should be encouraged. This will reassure employees that they can confidently talk about their mental health without repercussions, and this could potentially aid in reduction of suicide in the construction industry.

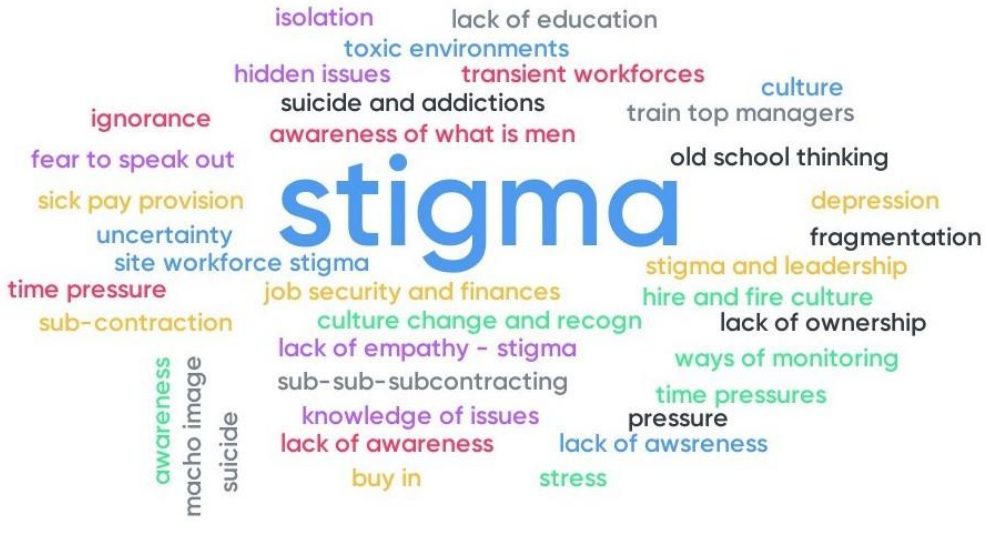

Figure 1: Word cloud of participants' responses regarding the number one issue within the construction industry (NB. Size of words represents number of similar responses)

4. Conclusion

The main issues raised by the participants of the MHFA training were the boundaries for the MHFAider in the workplace (including how to manage their new role and responsibilities). The level of relevance of the MHFA course material to the construction industry was another issue raised by the participants. They identified that without the ability to tailor the course material to suit the industry for the two-day training, it would be difficult to effectively meet the needs of the people working in the industry. Confidentiality issues at work and how to adapt MHFA to suit the existing health and safety policies and practices on site was raised by some of the participants. This is important as some of the workers are sub-contractors and not permanent site workers i.e. in the context of tracking their mental health and delivering MHFA to them. The complexity of the construction industry equally requires complex and thought-through solutions. Mental ill health varies across the demographics within the industry and has varying trigger points depending on the type of job and the customised stressors that the workers go through. Therefore, a one-size-fits-all solution cannot adequately deal with the complex issues at hand. The participants of the MHFA training identified that the course would benefit the industry more if it provided them with proper tools for their workplace. The same is echoed by the participants of the IOSH study where they expressed that most of those who had attended the training were 'office types', meaning that the training was ultimately geared to equip them best.

Different professions within the construction sector face varying mental health issues, so the need for customised help is paramount. The 'hire and fire' culture within the construction industry, and the high demands and job uncertainty that the workers go through to keep their jobs was emphasized by the participants. As a result of this, stigma on mental health is prevalent within the industry, and issues of confidentiality is an obvious necessity. Other matters include the inability to log mental health incidents for each employee as compared to when physical harm or incidents happens on site. Workers suffering from mental health issues may become a danger not only to themselves but also to others, especially if they are responsible for operating machineries or working at height. If workers' mental ill health is logged, and confidentiality is breached, that can potentially put them at the forefront of stigma, and the MHFAider may also lose credibility, effectively hindering the MHFAider from helping others in the future. Based on the course content of the MHFA England training; the main deliverables are the promotion of mental health awareness, increasing mental health literacy and understanding of mental health issues which effectively reduces stigma surrounding mental health, and equipping MHFAiders to signpost those in need to appropriate sources of help. However, it does not adequately address the

core issues of mental health specific to the construction industry and neither is there evidence of how the effect of having a MHFAider on site will positively influence the construction workers themselves, and the workplace as a whole.

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